

- **What is the High Flow Approach?**
- **Fundamental components and why needed**
- **Background to High Flow**
- **Alignment with National HIU model**
- **Supplementary information**



# The What – Chosen Topic

## One Devon High Intensity User Programme Implementation in Northern Devon - High Flow

What is Flow?

(It's not hospital flow or Floating Offshore Wind!)



Flow principles explained in 2 minutes

# About High Flow

## What are the fundamental components of Flow ?

We are centred around what matters to the person

We take a Team around the Person approach

We offer case worker support for those who need it

We co-ordinate services so that they 'flow' around the person rather than them 'bouncing around the system'

We drive change by highlighting gaps and failures that increase 'failure demand' and look for ways to create systemic change

## Why is it needed?

People most in need of support are least likely to receive it.

They are expected to fit in with what services need rather than the other way around and many describe feeling that no-one cares.

They feel 'bounced around' services and telling their story again and again, which can be distressing, particularly for people who have experienced trauma.

People feel distanced from the professionals that support them as they get referred to various providers for more specialised support.



**A WHOLE SYSTEM  
APPROACH TO  
A WHOLE PERSON**

## Background to High Flow

- Developed by the One Northern Devon partnership in 2019
- Went live in January 2022 with one full time caseworker employed by Encompass South West
- SRO - Superintendent Toby Davies
- Steering Group made up of primary care, secondary care, mental health care, social care, district councils, ambulance and police services
- Caseworker aims to support between 10 and 15 people per year
- When places become available, partners recommend their most complex or frequent attenders
- What matters conversations and Team around the Person meetings are key features
- Following High Flow, the approach was expanded and included Youth Flow, Community Mental Health Flow, Primary Care Flow, Pain Team Flow
- New Flows starting in 2024: Housing Flow and Leg Team Flow
- Evaluation data collected includes: outputs, outcomes (shortly also impact) and demand data
- High Flow Case Studies can be found [here](#)

# REDUCTION IN DEMAND

## Impacts on partners & system

In one year, six clients on the High Flow programme resulted in a reduction in demand of £103,831.92 across all the partner services.

These were: Northern Devon Healthcare Trust, South West Ambulance Service, Police, Primary Care Networks and Devon Partnership Trust.



Northern Devon Healthcare Trust  
-£ 42,150.00

South Western Ambulance  
Service -£ 23,331.92



Police  
-£ 36,382.00



Primary Care Network  
+£180.00

Devon Partnership  
Trust -£ 2,148.00



Total Reduction  
-£ 103,831.92



# Alignment with HIU model starting January 2024

- In 2019/20, NHS Operational Planning and Contracting Guidance set out that all health systems in England must implement a High Intensity Use service.
- High intensity use is greatest in areas of deprivation and across all age groups, it is associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation.
- People who attend A&E frequently are significantly more likely to die than people who don't.
- The One Devon service specification requires us to:
- Deliver a de-medicalised, non-criminal person-centred service to address the needs of people who are using multiple forms of healthcare more than, or differently than, expected
- They are identified through robust system data, which can be triangulated with South West Ambulance Service Trust, Emergency Departments, Devon Partnership Trust, Livewell, 111, 999 etc.
- Reduce urgent, secondary, and emergency care contacts, contributing to the 20% reduction required at Emergency Departments front doors.
- Build a learning, quality improvement capability into the service, which will benefit the people of Devon and the workforce, by (for example) leveraging a standardised suite of measures to assess quality and outcomes and a means for involved agencies to highlights areas of excellence, good practice, or concern across organisational boundaries.

# Who does High Flow support? Some 'personas'

## Michelle

- aged 37
- Re-homed to Devon with police support having fled severe domestic violence
- Numerous physical health conditions and ongoing physical and psychological effects of the injuries she received
- 22 admissions in 3 months
- convulsions/seizures/epilepsy
- lives in constant pain
- eating is painful due to jaw damage and some missing teeth
- alcohol dependent and over the counter drug addiction
- adult social care have safeguarding concerns about self-neglect and poor nutrition
- police have safeguarding concerns about a recent boyfriend
- brought in by ambulance usually late at night due to self harm/overdose
- at risk of eviction from her private landlord who 'has reached the end of his tether'

## Jamie

- age 26
- difficult childhood, with numerous traumatic experiences
- Used to enjoy playing guitar and was a talented squash player until his mental health deteriorated after a further trauma.
- Started to have anger issues and became argumentative with his family.
- Moved into a house of multiple occupation (HMO) which is in a poor state with no real kitchen area.
- Others in the HMO had a detrimental effect on him and his alcohol and drug use increased
- The police see him as vulnerable and have county lines concerns
- He has frequent crises involving drugs, alcohol, suicidal ideation
- Has been found unresponsive and/intoxicated/in street
- Has attended A&E 12 times in the last 3 months, brought in by ambulance, sometimes with police involvement
- never admitted & often leaves without treatment

## Mark

- age 45
- has COPD
- mild learning difficulties
- doesn't use medication reliably
- comes in by own transport
- would like to find work and has been looking but employers found him unreliable due to his frequent episodes off work

## Nicola

- age 62
- previous successful career
- car accident led to being unable to work poor mobility and feelings of isolation
- blackouts with unknown cause
- family lives abroad and lives in a rural location
- Mental health issues and increasing dependence on alcohol

## **SUPPLEMENTARY INFORMATION**

- **THEORY OF CHANGE**



# Root causes and their knock-on effects

## Root Causes

- More people with:
  - Increasingly complex lives
  - Increasing comorbidity & multimorbidity
- Increasingly severe social determinants of health, health inequality and mutually reinforcing co-existing risk factors for ill health
- Services increasingly focussed on resolving single cause presentations
- Lack of preventative and holistic interventions
- Those working across health and social care reporting concern that their individual values did not match the values they were able to display at work leading to dissatisfaction

- A small number of people in Devon have a repeating and often escalating number of presentations to the Emergency Department (ED) and other acute resources) indicating that their specific needs are not effectively identified or responded through the current non-personalised service model.
- This creates dissatisfaction in service response for individuals, and furthers a perception of alienation and dissatisfaction for staff who feel that they are unable to effectively treat individuals
- This also leads to a significant direct financial cost to the system and associated opportunity cost (waste).
- Inequality in outcomes are not addressed over time by the current service model for these individuals and therefore inequality tends to increase

## Effects

## Core Problems

- A failure to identify systematically those with unmet need.
- A failure to identify the root causes in a person's repeated presentation to ED leads to a failure to redirect a person's demand to more appropriate resources
- A standard approach supports an uncoordinated, non holistic approach to an individual's life and problems which can exacerbate the very problem the person appears to be presenting with and may fail to engage them in preventative work
- A repeated failure for some people to have their needs effectively addressed in an ED contact leads to disengagement and dissatisfaction
- ED is an expensive intervention with significant opportunity cost and real cost

## Change we want to achieve

- Data driven approach prioritising resources towards those with most need i.e. people who attend A&E multiple times, starting with the top 20 and incrementally towards the top 100, per LCP (Focus on ED attendances and non-elective admissions in terms of data and identification of cohort).
- A strengths based and trauma informed approach to the individual that develops a creative, contextual, holistic formulation and plan for that person that includes a “what matters to me” conversation
- The plan for that person is a coordinated, team around the person approach which provides positive outcomes for people, services, and systems
- An assertive outreach approach will be supported and utilised, connecting with people where they are comfortable with professionals they want to relate to, in a person-centred way
- The model of personalised care will be used as an enabler to drive forward culture change and embed shared decision making wider than the High Flow programme
- Support the development of community based support and services across the LCPs – using existing networks and partners where effective services are already in place.
- A financially sustainable model which releases expenditure from acute provision to support community and preventative interventions.

# How we will achieve this change

## Inputs

### Encompass (employer):

- 2.5 WTE Flow Case Workers
- 1.0 WTE Flow Project & Line Manager

### RDUHT:

- 0.4 OND Service Manager
- ED Clinician (FA Meeting)

### DPT:

- Lead Clinician
- ED Liaison (FA meeeting)

### NHS Devon:

- BI analyst

### OND partners

(RDUHT, DPT, SWAST, PCNs, Police, NDC, TDC, DCC):

- Data providers
- MDT practitioners
- Steering Group members
- Working Group members

### OND LCP Board

## Activities

### Project set-up

- Create governance structure (OND-LCP & ICB relationships) (to include N&E High Flow Steering Group; Caseworker Team meetings; Frequent Attenders meetings, Data Collection meetings)
- Create Service Specification
- Create Job Profiles
- Create comms & engagement plan
- Create data collection plan and ED list (demand data, person data, activity data)
- Information Governance - ensure all partners have signed ISA & DPIA & honorary contracts in place including template consent forms
- Complete Equality Impact Assessment
- Create Reporting Plan
- Create finance & budget plan including resource requirements
- Employment contracts & SLAs with provider
- Create evaluation plan
- Leadership charter created

### Project delivery

- Obtaining ED list of top 250 most frequent attenders on a monthly basis
- Interface with partners to highlight potential priority cases (including Frequent Attender meetings)
- Assertive outreach by Flow Caseworkers to people on the list
- What matters to me conversations
- Goal setting - agreeing joint action plan
- 1 to 1 case work, signposting & referrals to support, supporting to attend appointments, advocacy, action planning and progress reviews
- Team around the Person (TAP) meetings organised
- Connecting into community through One Community Developers and other opportunities
- OND LCP Board considers learning from delivery and how to enable systematic change

### Project monitoring

Data collection from all partners and ED list  
Caseworker completion of case tracker and outcomes document  
Inputting outcomes onto Impact Reporting tool

### Project set-up

- Project set up documents completed

### Project delivery

- Between 40\* (for rural areas) and 50 people per year supported by Flow taken from list of top 250 frequent attenders to ED
- 1 to 1 meetings take place in an assertive outreach approach
- What Matters conversations
- Team around the Person meetings
- Community around the Person connections made

### Project monitoring

- Report outlining numbers of people, their ED and other public sector attendances and progress on their goals provided monthly to OND LCP and ICB

## Ouputs